Minor

Chesterfield Orthodontics
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Dr. Robert Yoon

Date: _____

Patient's Name: _____ **Preferred name:** _____
First Name Last Name

Address: _____

Birth Date: _____ **Age:** _____ **Sex:** ___ **General Dentist:** _____

Email for Appointment Reminders: _____ **Phone number for reminders:** _____

Whom may we thank for referring you to our office? _____

Other Family Members in Treatment:

_____

Fathers Information:

Dr, Mr _____ **Responsible Party: Y / N Marital Status:** _____
First Name Last Name

Home Address: _____

Social Security Number: _____ **Birth Date:** _____ **Relationship:** _____

Email: _____ **Home Number:** _____ **Cell Number:** _____

Employed By: _____ **Occupation:** _____

Does Father have Dental / Orthodontic Insurance? Y/N Name of Insurance Company: _____

Member ID Number: _____ **Group Number:** _____ **Telephone Number:** _____

Mother's Information:

Dr, Mrs, Ms _____ **Responsible Party: Y / N Marital Status:** _____
First Name Last Name

Home Address: _____

Social Security Number: _____ **Birth Date:** _____ **Relationship:** _____

Email: _____ **Home Number:** _____ **Cell Number:** _____

Employed By: _____ **Occupation:** _____

Does Mother have Dental / Orthodontic Insurance? Y/N Name of Insurance Company: _____

Member ID Number: _____ **Group Number:** _____ **Telephone Number:** _____

If responsible party is other than the patient's parents, please give information:

Name: _____ **Relationship to Patient:** _____

Address: _____ **Phone Number:** _____

If divorce is involved, who is the Custodial Parent? _____

May Patient Information be released to the noncustodial Parent? _____

Parent / Guardian Signature: _____ **Date:** _____

Health Questionnaire

Date: _____

Patient's Name: _____ **Birth Date:** _____

Date of Last Dental Visit: _____ **Family Physician:** _____

Have you ever had the following?

Orthodontic Consultation: Y/N Date: _____ **Dr.** _____

Orthodontic Treatment: Y/N Date: _____ **Dr.** _____

Do you have or have you had any of the following oral conditions?

Y	N	Sensitive teeth	Y	N	Bleeding gums	Y	N	Oral habits (thumb sucking, etc)
Y	N	Clenching or grinding	Y	N	Pain around ear	Y	N	Pain in the jaw, face
Y	N	Jaw joint sounds or pain	Y	N	Pain when opening mouth	Y	N	Jaw joint sounds or pain
Y	N	Bad breath	Y	N	Dry mouth	Y	N	Mouth breathing
Y	N	Poorly functioning teeth	Y	N	Food wedging between teeth	Y	N	Inability to floss between teeth
Y	N	Discolored teeth	Y	N	Swelling or lumps in the mouth	Y	N	Tobacco use

Do you have or have you had any of the following medical conditions?

Y	N	Rheumatic fever	Y	N	Congenital heart lesions/murmur	Y	N	Heart condition
Y	N	Diabetes	Y	N	Arthritis, swollen joints	Y	N	Tuberculosis
Y	N	Kidney problems	Y	N	Swallowing problems	Y	N	Hepatitis type _____.
Y	N	Asthma	Y	N	Inflammatory Rheumatism	Y	N	Convulsions or seizure
Y	N	Liver disease	Y	N	Yellow jaundice	Y	N	Sinus problems
Y	N	Severe headaches	Y	N	High blood pressure	Y	N	Low blood pressure
Y	N	Eye problems	Y	N	Dizziness or fainting	Y	N	Venereal disease
Y	N	Nose bleeds	Y	N	Ear problems	Y	N	Anemia
Y	N	Easy bruising	Y	N	Speech problems	Y	N	HIV positive
Y	N	ADD/ADHS						

Is patient allergic to latex, metal or vinyl? If yes, please explain: _____

Is patient currently under a physician's care? If yes, please describe _____

Has patient ever been hospitalized or had any serious illness? If yes, please describe _____

_____

Does patient have any drug allergies? If yes, list medications _____

Is patient taking any medications? If yes, list medications _____

_____

Female patients – could patient possibly be pregnant at the present time? _____

Has patient ever taken any medication for osteoporosis? _____

Parent / Guardian Signature: _____ **Date:** _____